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ABSTRACT

This paper describes a program of free, short-term, individual bereavement counseling for survivors of sudden death in Marin County, California. Co-sponsors are Marin Suicide Prevention Center and Marin County Coroner's Office. Most survivors are initially referred to the program by the coroner at the time of certifying cause of death, others are referred by third parties, and some are self-referred. Clients may not be in therapy, and the death may not have occurred more than a year prior to the referral. All known primary survivors are contacted through outreach calls during which the program is offerred. About one-third of those contacted accept. Of the 71 cases reported here, two-thirds invclved violent deaths of which one-half were suicides. Counselors are volunteers working in pairs, who are trained and supervised by Marin Suicide Prevention Center. The program has been functioning for six years without funding, other than administrative support from sponsoring agencies. Observations indicate that the most willing to accept help are: (1) survivors of highly traumatic deaths; (2) unsuccessful suicide attempters; (3) female survivors grieving the loss of males; and (4) survivors who lose a spouse, lover or child. (Author/CKJ)

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GRIEF COUNSELING FOR SURVIVORS OF SUDDEN DEATH (SOSD)

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Annual Meeting
American Association of Suicidology
Denver, Colo.

May 12, 1979

Grief Counseling Program
P.O. Box 792
San Anselmo, Ca. 94960

Co-sponsored by:

Marin Suicide Prevention Center
Office of the Marin County Coroner

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GRIEF COUNSELING FOR SURVIVORS OF SUDDEN DEATH

Introduction: This paper is a description of the Marin County Grief Counseling Program for Survivors of Sudden Death (SOSD). This program is a unique model, pilot development which performs an important service to the community. It is unique in that:

(1) it provides short term, free bereavement counseling by teams of specially trained volunteers;

(2) it is jointly sponsored by the county coroner's office and the local suicide prevention center;

(3) it is an outreach program in which survivors are contacted and offerred help rather than having to seek it out;

(4) survivors of all sudden and unexpected deaths are automatically contacted by the coroner's office who must investigate each case and certify cause of death;

(5) a curriculum has been developed specifically for training lay volunteers to counsel the bereaved; and

(6) the program has been established and operational for over 6 years with virtually no funding.

HISTORY

The Marin Suicide Prevention Center (Marin County, California), began operations in 1968 and presently handles between 1600 and 1800 calls per month, with a corps of volunteer telephone counselors numbering over 200 and a paid staff of 6. The phones are manned 24 hours per day by 10 trained counselors in 5 shifts.

Extra counselors are assigned to work during peak stress seasons. The Center averages one emergency crisis requiring intervention every 50 hours. The continual need for replacing volunteers who drop out requires the Center to run its 33 hour training classes back to back. It is also the major training agency for other organizations doing crisis intervention counseling and carries on regular, accredited continuing education seminars for other professional groups.

In 1973, the principal of a local junior high school called upon the Center to assist the student body and faculty following the suicide of a popular student. The Center's director, Richard Reubin, Dr. P.H., selected key staff members and volunteers and conducted assemblies, small groups and individual sessions for students and teachers who wanted help. The parents of the suicided student asked for help and the program of grief counseling for Survivors of Suicide (SOS) was begun. Subsequently, the county's deputy coroner, who had been close to MSPC from its inception, called upon the Center to assist in several other suicides. Gradually the relationship between the two organizations evolved into operational cooperation.

Most of the counseling was firmly rooted in principals of psychotherapy, but conducted by counselors who were not professionals so it was a sort of seat-of-the-pants approach. The need for training became urgent, but no manuals or other models existed. A pilot course was designed by Dr. Reubin and Alice Demi, R.N., then coordinator of out-patient services of Hospice of Marin, who was working on her doctorate in the field of services to the bereaved. The first training class, in the Fall of 1976, con-

tained 12 students, most of whom became grief counselors and continue to be the core group today.

By this time, the county coroner had asked the Center to provide counseling to survivors of sudden and unexpected deaths other than suicide. This already close association was formalized in mid-1977 by action of the Marin County Board of Supervisors who agreed to implement a proposal to establish a Grief Counseling program for Survivors of Sudden Death (SOSD) to be conducted jointly by the coroner's office and the MSPC.

Once the proposal was adopted, a brochure was prepared, administrative supports were intensified and training was provided for additional counselors. The program was officially inaugurated in late 1977 with 20 trained volunteer counselors doing both outreach calls to prospective clients and conducting counseling sessions with those who accepted the service. The coroner's office is responsible for initating referrals while the Center administers and supervises the training and counseling.

PROGRAM

SOSD grief counseling is not therapy. Indeed, if the bereaved are already in therapy they are not eligible to receive counseling. If the need for therapy becomes evident, clients are urged to obtain it and referrals will be given upon request. The program is free and available to anyone who has suffered the unexpected death of a loved one during the past year. It is short term, usually 8 weekly sessions of one or two hours each. Meetings may be held in the bereaved's home, MSPC offices or any other convenient place. Counselors work in teams of 2 and remain together throughout the duration of the case.

Referrals come from three sources: the coroner's office; self-referrals received over either the crisis or grief counseling telephone lines; or 3rd party referrals also received by telephone.

Coroner Referrals: Since the coroner must certify all deaths that are unattended, violent or of equivocal cause, his records contain practically every sudden death which occurs in the county. The main exception to this procedure is death involving cardiovascular problems attended by a physician who has responded under emergency conditions. Coroner certifications account for about one-fourth of all deaths in the county which in 1976 numbered a little over 1400. Thus, coroner certifications account for about 300 referrals per year, providing a comprehensive source of outreach potential for the grief counseling program.

When the coroner is called in to investigate a death, he identifies the primary survivor to whom he subsequently sends the death certificate. Along with this document, he sends a personal letter of condolence, refers the survivor to the SOSD program and encloses a brochure. If the primary survivor is someone other than a next-of-kin (who would receive the death certificate), such as a lover or extremely close friend, he also makes a note of that person's name and relationship to the deceased and sends him or her a letter of condolence and brochure. He then sends SOSD a copy of the death certificate and the investigative report, circling the names of all primary survivors encountered during his investigation.

Self and 3rd Party Referrals: These referrals generally come in through the crisis lines from people who are reacting to a recent

loss or expressing concern for someone they know who is grieving. Crisis counselors get all necessary information and pass it on to the SOSD coordinator who then processes it for an outreach phone call. Callers may not have known about the service and called the crisis line for whatever help was available, or they may have learned about it through the media or word-of-mouth and ask for it specifically. A number of referrals are made by MSPC or SOSD counselors or their friends and acquaintances.

Outreach Calls: All referrals are followed up by outreach calls conducted by SOSD counselors. These calls serve a variety of purposes:

(1) an expression of sympathy;

(2) information is elicited on how the survivor is reacting to the loss (these calls are frequently lengthy and may become mini-counseling sessions if the counselor detects an urgent need that should not be postponed);

(3) basic intake information is gathered for counseling purposes if the bereaved becomes a client;

(4) identification is made of other survivors who might benefit from outreach calls or counseling;

(5) the bereaved's support system is identified;

(6) a lethality assessment of the bereaved is made and a referral to the suicide prevention crisis line is made if appropriate;

(7) the bereaved's eligibility for the program is determined;

(8) the bereaved person makes a decision on the program or asks for a call-back at a later time.

About one-fourth of those contacted express interest in the

counseling and about one-half of them become clients.

Case Initiation: When survivors express a desire for counseling, they are told that a team of 2 counselors will be assigned and one of them will call within a few days to set up date, time and place for the first session. Outreach calls are fully written up and statistical forms are completed. Pending cases are routed to the SOSD coordinator who contacts the counselors, sets up the new case and enters the name in an SOSD file in the crisis intervention telephone room for ready reference by phone counselors who also answer the grief lines.

Counselors contact the survivor and counseling begins. Referrals from the coroner usually arrive within two or three weeks after the death has occurred and counseling is generally underway within another week. Beginning counseling in the third or fourth week after death seems to be a natural time because this generally coincides with the dropping off of other support systems which ordinarily function during the most acute phase of shock and onset of reality. In some cases, the coroner will notify us by phone following his investigation and the outreach call will be made immediately, with counseling beginning within a few days after the death. Generally, the more violent the death, the faster the referral system operates.

Self and 3rd party referrals may be received anywhere from immediately after the death to many months later. Some of these referrals are received from persons initially contacted earlier who chose not to participate in the program at that time.

Program Goals: As presented in the program brochure, goals are:

(1) give reassurance and stability when you need it

(2) help you and your family to communicate honestly and openly

(3) provide a supportive atmosphere in which to explore feelings of regret and remorse in which you can express your grief

(4) help give you the patience to work through the long process of grief

(5) explore resources to help resolve any financial and everyday difficulties you may have

(6) discuss and explore the possibilities which the future holds for you

Counseling Rationale and Content: SOSD grief counseling is rooted in what Carkuff (1969) call "the principle of concreteness as a necessary facilitative condition for effective psychotherapy." Switzer (1972) points out that the shock and denial which is the usual first reaction to the death of an emotionally related person is the attempt to deal with the intense anxiety of loss and threat to the self. In most instances, he says, shock and denial are not capable of handling the combined power of the internal feelings and the external reality of the death, with the result that there is an outpouring of feelings and expression of pain, "...the variety of emotions not always clearly differentiated and identified at this point, but yet a rather uninhibited cathartic expression." When this has not taken place, he maintains, further stages of grief work cannot be accomplished.

Accordingly, in the first session, SOSD counselors ask the client to recount the "death history" of the deceased and themselves. This involves details about the death and the events surrounding it plus details about the expressions of feelings which the survivor had been experiencing at the time. It is, as one SOSD consultant put it, "enabling the bereaved person to make the

unspeakable, speakable." Switzer describes this process as a "very directive, sensitively aggressive lancing of a psychic wound that is still festering."

As the counselers participate in this reliving of those painful times and feelings, validating the mourner's reactions and thoughts, they lay the foundations for a safe atmosphere in which the mourner can begin to trust them. Counselors respond empathetically, discuss the grieving process, make note of problem areas for future consideration, describe the program, answer questions, give assurance and arrange for the next meeting. At some point, clients are always asked if they have felt suicidal at any time during their grief and, depending on their degree of lethality as assessed by the counselors, suicide prevention counseling may be encouraged.

Following this and all other sessions, counselors make note of highlights, debrief one another and one of them files a complete written report and plan for the next session (they usually do this task alternately). The report is read by the coordinator who may respond with questions, comments or suggestions. It is then filed and the case is periodically reviewed by the supervising MSPC staff assigned SOSD responsibilities.

Subsequent sessions begin with whatever the bereaved brings to the session and then proceed toward the goal of helping the person eventually "let go" of the deceased. Counselors are directive and active in asking about the deceased--as a person, about their relationship, probing for all possible memories, what they did together, what they said, what feelings were expressed by both, the meaning of all these things to them both. Such counseling touches upon needs which Switzer (1969) has again

put well:

(1) the need to release one's self from external ties to the lost person

(2) the need to reaffirm one's self as a worthwhile person

(3) the need to rekindle as presently potent earlier good images, those internalize aspects of the other and the relationship which had been at any earlier time gratifying.

Where the counseling team is working with more than one survivor, session may deal with the dynamics of the group's interactions, problems of communication, negotiating permission for each to grieve in his or her own individual way. Frequently, counselors may split up and each work separately with survivors or meet with them individually, necessitating additional sessions. The goal is always to assist the group to be supportive of each individual's grief work and to encourage dialogue about the deceased.

About the sixth session, two additional matters come up: referral for therapy, if it is indicated, and preparation for terminating the counseling program. Ending counseling always involves another loss for the bereaved so it introduces an element of immediacy--what's happening at this moment, loose ends to be tied up, considerations about the future. This leads to the whole issue of "letting go"--of accepting separation--and gives further opportunity for the expression of other losses, hurts, angers, threats, feelings of unfairness. During the whole process, counselors watch for signs of pathological grieving in order to implement whatever intervention plans may be appropriate. As Pincus (1974) points out, since there is no norm for mourning or

the process of adaptation, the only valid criterion for pathological grief is "an inability to cope with life." Eight sessions is often a sufficient time to ascertain such inability and the SOSD program frequently operates as an entry point into therapy. Therapy referrals are made in about one-third of all cases.

Counselors make note of important anniversary dates and keep in contact for at least a year following the last session. Such contacts are generally by phone, occasionally face-to-face. To date, no client satisfaction survey has been conducted, but many clients respond with letters or cards of appreciation and donations to the program.

STATISTICAL DATA

From its beginning in 1973 until the program was formalized with the coroner's office co-sponsorhip, it was carried on rather informally as an extension of the Marin Suicide Prevention Center. Procedures, data collection, development of forms and methodology all evolved gradually as needs made demands. In October 1977, a part time coordinator was obtained, providing the most consistent collection of data since the program's inception. All information presented below is drawn from data collected since then.

Referrals and Outreach Calls: The key to the SOSD program is outreach to those in need. The program does not wait for the bereaved to find it--it goes to them as quickly as it becomes aware of their loss and offers its services when most desparately needed. When the coroner began making referrals on a regular basis, the volume of outreach calls rose dramatically. New counselors receive as their first assignment a sheaf of coro-

ner's referrals and make outreach calls. These calls result in many satisfactions for the callers but are also hard work due to their nature and high volume. Calls coming in from self or 3rd party referrals, being more personal in nature, produce more cases proportionately than referrals from the coroner's office. Over a 14 month period, SOSD callers logged the following results from 287 outreach calls:

OUTREACH CALLS FROM CORONER REFERRALS, BY MODE* OF DEATH

	N	A	S	H	Eq	Totals
Referrals	176	46	43	6	16	287
(%)	(61%)	(16%)	(15%)	(2%)	(6%)	(100%)

Of these 287 outreach calls to primary survivors, 59% indicated that they were "doing all right" or weren't interested; 11% said they would consider the program; and 14% immediately requested counseling. About 1/2 of those in the latter two categories eventually became clients.

CORONER OUTREACH CALL & CASES BY MODE OF DEATH

	N	A	S	H	Eq	Totals
# calls	176	46	43	6	16	287
# deaths in 33 cases	10	10	10	1	5	36
(%)	(6%)	(22%)	(23%)	(17%)	(31%)	(13%)

Note that while sudden natural deaths accounted for 61% of the referrals, only 6% of the cases came from this group of survivors. The more violent modes of death (especially equi-

*Mode of death designations made by the coroner are Natural (N), Accident (A), Suicide (S), Homicide (H) and Equivocal (Eq). Equivocal means that the mode cannot be definitely determined. It frequently raises a question of self-inflicted death and occasionally a question of homicide.

vocal) generated a significantly larger number of cases proportionately. This seems to support the notion reflected in much of the literature that the greater the death trauma, the greater the sufferings of the bereaved and the more amenable they are to help. This observation is supported in the data showing cases from other sources of referral:

71 CASES BY SOURCE OF REFERRAL AND MODE OF DEATH

	N	A	S	H	Eq	Total Deaths
Self-Referral 23 cases	7 (30.5%)	3 (13%)	10 (43.5%)	0 (0%)	3 (13%)	23 (100%)
3rd party 15 cases	7 (47%)	2 (13%)	5 (33%)	1 (7%)	0 (0%)	15 (100%)
Coroner Ref. 33 cases	10 (28%)	10 (28%)	10 (28%)	1 (2%)	5 (14%)	36 (100%)
Totals	24 (32%)	15 (20%)	25 (34%)	2 (3%)	8 (11%)	74 (100%)

In noting that suicide accounts for the largest group of cases (it is especially notable in self-referrals), one may ask if this reflects the program's association with a suicide prevention center. Having no comparable figures from any other source, it is impossible at this time to determine such an influence.

Cases: In the SOSD program, three varieties of client settings have been dealt with: (1) single client, not necessarily unmarried, but the only person among other survivors who requested counseling; groupings of several adults which might have included, in addition to a spouse or lover, one or more parents, children, siblings, other relatives or friends; and family groups, including children.

CASES BY CLIENT SETTING

Single adult	41	(58%)
Multiple adults	15	(21%)
Family (including children)	15	(21%)

Some cases began as single adult types and became one of the others as additional survivors joined in. If such a change occurred, they are listed in the category most descriptive of the grouping.

Not all cases have been carried through the full 8 sessions. At the time of writing, of the 71 cases reported here, 13 are still current while the other 58 have terminated. Of that 58:

42 went full term
10 terminated mid-way
6 terminated after 1 session

Interestingly, 3 of the latter 6 dealt with equivocal mode of death cases, while natural, accident and suicide had one each. In summary, 73% finished and 17% went at least mid-way, making a total of 90% of cases begun in which counseling was provided in depth. Several finished at the mid-way point because of a mutual acknowledgement that the need was no longer urgent and adequate support systems were present. Several cases terminated early when clients moved away. Every case involving children went at least mid-way.

Clients and Deceased: Several cases involved more than one death, giving a total of 74 deceased persons being mourned in 71 cases. The deceased included more than twice as many males as females:

NUMBER & SEX OF DECEASED BY MODE OF DEATH

	N	A	S	H	Eq	Totals
Females	9 (38%)	4 (27%)	9 (36%)	0 (0%)	1 (13%)	23 (31%)
Males	15 (62%)	11 (73%)	16 (64%)	2 (100%)	7 (87%)	51 (69%)
Totals	24 (100%)	15 (100%)	25 (100%)	2 (100%)	8 (100%)	74 (100%)

By contrast, the survivor/clients included nearly three times as many females as males:

CLIENTS & DECEASED BY RELATIONSHIP & SEX

Primary Clients			Deceased		
	♀	♂	♀	♂	
31 spouses	27	4	4	27	
7 lovers	6	1	2	5	(Homosexual: 2♀ & 1♂)
6 single pareants	6	0	5	2	(children)
13 both parents	13	13	6	9	(children)
4 children	4	0	3	1	(parents)
6 siblings	4	2	1	5	
3 friends	3	0	2	1	
1 cousin	0	1	0	1	
71	63	21	23	51	
	84		74		

In addition to the 84 primary survivors noted above, there were 68 other survivors included in the 71 cases, making a total of 152 counselees.

As is seen above, SOSD cases tend to involve females grieving for lost males. Note that of the 21 bereaved males, 13 were mourning the loss of children, 1 the loss of a male lover, and 1 the loss of a male cousin. Only 6 cases dealt with males requesting counseling to help them in their grieving for a lost spouse, female lover, sibling or parent. It should be further observed that the 13 grieving male parents in every case accompanied their spouses in the counseling. These data seem to support the

frequently noted cultural pattern in which women have social permission to "go public" with their grieving but men must maintain a stoicism in which grief is expressed only in private or repressed entirely.

Literature on bereavement often suggests that the losses of spouse/lover or of children are the most difficult from which to recover. In support of that, it should be noted that 54% of the SOSD cases involved loss of spouse or lover and 28% the loss of children--a total of 82% of all cases reported on.

In regard to age groups of both clients and deceased, there was a fairly regular pattern of fewer at both ends of the continuum and a rising number in the middle-age period of 40-59. An exception is noted for the 20-29 age group in which there is a disproportionate number of deceased caused by the high indidence of suicide within that age group:

CLIENTS & DECEASED BY AGE & SEX

AGE GROUPS	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70+
Clients								
♀63	0	1	11	14	15	15	4	3
♂21	0	1	2	3	7	4	2	2
tot. 84	0	2	13	17	22	19	6	5
Deceased								
♀23	2	4	4	3	4	3	1	2
♂51	1	5	12	4	10	14	2	3
tot. 74	3	9	16	7	14	17	3	5
Clients: 31 spouses & 7 lovers								
♀33	0	0	4	6	9	9	3	2
♂5	0	0	0	1	1	1	0	2
tot. 38	0	0	4	7	10	10	3	4
Deceased: by suicide								
♀ 9	0	0	4	1	2	1	1	0
♂16	0	2	7	1	2	3	1	0
tot. 25	0	2	11	2	4	4	2	2

In noting the high incidence of suicide in the 20-29 year group, there is graphic evidence of the severe trauma caused to survivors of youthful acts of self-destruction. Suicide is highly visible in the SOSD program, both as the largest modal group and as the largest generator of self-referrals. Suicidal ideation is a common grief reaction among survivors of suicide and other sudden death. These factors recommend a close association between bereavement counseling and suicide prevention counseling. They also underscore the need for bereavement counselors to have crisis intervention training such as is provided through suicide prevention services. The SOSD model makes sense.

COUNSELORS

All SOSD counselors are volunteers, although about 1/3 are professional therapists or in professional training programs for certification and licensing. Another 1/4 come from the medical services field, including nurses and, at present, 1 physician. About 85% have been suicide prevention telephone counselors or at least taken the training and served an apprenticeship. One-third of those who have not had the SP training have subsequently taken the training on their own intiative.

Most SOSD counselors are over 30 and about 75% are women. Over 50% have suffered the loss of a significant other. They enter the program after rigorous training and screening.

TRAINING

Since there was no existing model for the early grief counseling training, the first class was modelled on the MSPC's crisis intervention course. That model remains largely intact

after four training classes, but the content has evolved so that it is a totally differentkind of training experience. It tends to be more deeply involving of the student personally because all have suffered losses of one kind or another and all face their own mortality at a level seldom reached in suicide prevention training.

The 30 hours of training (10-3 hour classes) are roughly divided into 1/2 lecture and 1/2 directed and supervised psychodramas and role playing. Lecturers are drawn from staff, program counselors and guest specialists from allied professions. Trainees go through initial screening interviews and are assigned to advisors who meet with them 3 times for progress evaluations. Each trainee is required to turn in two homework assignments, participate as counselor in 4 psychodramas and as client in as many others as possible. Psychodrama groups typically contain 5 students and 2 evaluators. The ratio between students and training staff is 3:2.

Nearly all trainees are invited to participate in the program with only a few screened out. New counselors are paired with experienced ones for their first few cases. The staff and SOSD coordinator attempt to match up counseling team members by strengths and styles and make every effort to select counsleors to fit particular needs of individual clients.

Curriculum: The 30 hours of training is composed of approximately 1/3 sensitization to death and grieving, 1/3 to information-giving and 1/3 to counseling procedures. Sensitization involves a number of written and experiential exercises which focus on the trainee's own thoughts of death, past losses and griefs, and eliciting such memories and experiences from one another. The

psychodramas, besides being a primary training tool, invariably become the central sensitizing experience through their powerful simulation of reality and the intensity of involvment required in dealing face-to-face with issues of death and grief.

Information-giving stresses program history, loss and grief processes, needs of the bereaved, factors in grief reactions, support systems, dreams and metaphysical/paranormal aspects of grieving, child and adolescent breavement, and community resources. Counseling procedures emphasize techniques, evaluations, obtaining death histories, making outreach calls, setting limits, making lethality assessments, obtaining closure, terminating sessions, working with a partner, planning and debriefing, emergency procedures and ethical conduct.

After a trainee successfully completes his or her training and has been assigned to case work, attendance at regular ongoing training sessions is required. These sessions are held monthly and include additional training, speakers and case discussions.

The training staff conducts additional accredited continuing education seminars for training grief counselors in other organizations and fields.

FUNDING

From the beginning, this program has had to exist on virtually no special funding. Until the coroner's office became a co-sponsor, all costs and services were absorbed by the MSPC. The coroner now contributes office help required for referrals and picks up the cost of the brochures.

One of the volunteer counselors was able to get a one year

vocational rehabilitation grant (due to his recovery from a disabling illness) which allowed him to work as a 3/4 time SOSD coordinator. His efforts were largely responsible for setting the program on its feet. When his grant terminated, so did his services, except as a volunteer counselor. His responsibilities were assumed sporadically by volunteers and general coordination fell back upon the shoulders of already over-worked MSPC staff. A request for a CETA postion to resume the work of coordinator is expected to be approved in mid-summer 1979.

NEW PROPOSAL

The coroner is presently negotiating with the Marin County Board of Supervisors for an extensive enlargement of the SOSD program. This would provide services to survivors of all deaths in the county if they are not already in therapy or assisted by some other agency such as Hospice of Marin. If this proposal is adopted in mid-summer, 1979, it will provide several paid staff positions, new quarters and working funds, including mileage for counselors. Program changes will focus on the development of group counseling and cooperation with a large number of community organizations such as the medical association, churches and community mental health.

RESEARCH

The Marin Suicide Prevention Center has focused on services and training and has not been a frequent contributor to research efforts in the study of suicide or suicide prevention, although it long ago adopted an extensive data collection system and has a rich bank of information waiting to be tapped. In the area

of bereavement and grief counseling, however, several studies are under consideration by SOSD and MSPC staff. Proposals should be ready soon.

CONCLUSION

The Marin Grief Counseling Program for Survivors of Sudden Death is a major and innovative service to the community, meeting a need which is not being met by other institutions. The model is replicable and can be established in any community where the appropriate agencies exist to sponsor it and the community desires it enough to provide the volunteers which make it possible.

Suicide prevention centers are natural sponsors because of their specialized emphasis on crisis intervention, their established and effective training capablities and ther community acceptance. Such a program provides a rich source of data in the study of grief and mourning at all stages of bereavement, with ready access to survivors of all modes of death.

In its sixth year, the SOSD program has reached a level of sophistication which enables it to make available to other communities and agencies a cadre of consultant/trainers. Accompanying the current interest in "death and dying" is a growing awareness of the need for more and better bereavement counseling to the general public. The challenge to provide such a service is immense. The satisfactions of working productively in this new field are tremendous. The Marin Grief Counseling staff and volunteer counselors urge other agencies to join them in this important new development in human services.

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May 10, 1979

REFERENCES

Carkuff, R. Helping and Human Relations, Holt, Rinehart and Winston: N.Y., 1969.

Pincus, Lily, Death and the Family: The Importance of Mourning, 1974.

Switzer, David, "Repressed Affect and Memory Reactive to Grief: A Case Fragment," Omega, Vol 3, No. 2, 1972.

Switzer, David, The Dynamics of Grief, Abingdon Press:New York, 1970.